DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			X3) DATE SURVEY COMPLETED
		445516	B. WING			R 07/12/2019
		443310	B, 111110		CODE	07/12/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CREEKS	IDE CENTER FOR RE	EHABILITATION AND HEALING		306 W DUE WEST AVENUE MADISON, TN 37115		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		E APPROPRI	
{K 000}	INITIAL COMMENT	rs	{K 00	00}		
	07/12/2019 for all p 06/28/2019. All def corrected, and no n	t survey was conducted on revious deficiencies cited on ficiencies have been new non compliance was is in compliance with all ed.		C = A	e= 35 · · ·	- 8 -
13						
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN1939

OMB NO. 0938-0391 **GENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING B. WING 445516 06/28/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVENUE CREEKSIDE CENTER FOR REHABILITATION AND HEALING MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) {K 000} {K 000} INITIAL COMMENTS Stories: 1 K 321 7/3/19 Construction Type: NFPA, II (000); IBC, II unprotected A new door was installed on the Some plans available on site basement accounting storage room Constructed: 1968 to ensure latching on 7/3/19. Sprinklered: Yes Census: 130 A 100% inspection of all other facility doors was conducted on 6/28/19 to ensure all A Life Safety Code Follow up Survey was were in compliance with the requirements of conducted by the State of Tennessee Department K 321. of Health Division of Health Licensure and Regulation Office of Health Care Facilities on The Director of Maintenance was in-serviced 06/28/2019. During this Life Safety Follow up on 7/3/19 as to the requirements listed on the Survey, Creekside Center for Rehabilitation and Healing was found not in substantial compliance 2567 it relates to the condition of doors throughout the center. with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), A 100% audit of all doors will be completed monthly Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard For the next (3) months to ensure continued compliance with K 321 and the results will be 101-2012. reported in the monthly QAPI meeting June -The requirement at 42 (CFR), Subpart 483.70(a) August 2019 or until substantial compliance is NOT MET as evidenced by: maintained. {K 321} Hazardous Areas - Enclosure {K 321} CFR(s): NFPA 101 The results of the SS=D audits will be presented by the Hazardous Areas - Enclosure Director of Maintenance Hazardous areas are protected by a fire barrier in the monthly Quality Assurance having 1-hour fire resistance rating (with 3/4 hour meeting to assure compliance fire rated doors) or an automatic fire extinguishing with the requirements of K 321. system in accordance with 8.7.1 or 19.3.5.9. June - August 2019 or until substantial When the approved automatic fire extinguishing compliance is maintained. system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

In day

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: 3C8S22

Facility ID: TN1939

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO	0938-0391	
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING		TE SURVEY MPLETED
		445516	B, WING			R 5/28/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
CREEK	SIDE CENTER FOR RE	HABILITATION AND HEALING		306 W DUE WEST AVENUE MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{K 321}	from the bottom of the Describe the floor and hazardous areas the 19.3.2.1, 19.3.5.9 Area Separation N/A a. Boiler and Fuel-Fib. Laundries (larger c. Repair, Maintenand Soiled Linen Roome. Trash Collection (exceeding 64 gallouf. Combustible Stora (over 50 square feeting. Laboratories (if cl. Hazard - see K322) This REQUIREMEN by: Based on observation of the control of the contr	at do not exceed 48 inches the door. Ind zone locations of at are deficient in REMARKS. Automatic Sprinkler Auto	{K 32	The Quality Assurance Performance Improvement Committee will inclubut not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers Business Office Manager, Social Septimetror, Director, Dietary Manager, Housek & Laundry Director, and Maintenar Director.	de , vices eeping	
{K 541} SS=D	the door to the base room did not self-clo NFPA 101, 19.3.2.1. The Maintenance Di deficiency was ident acknowledged this d conference (via phor Rubbish Chutes, Inc CFR(s): NFPA 101	d: 8/2019 at 8:39 AM, revealed ment accounting storage se and latch within the frame.	{K 54	1}		

OMB NO 0938-0391

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO.	0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING		E SURVEY PLETED
		445540	D IAMAIG			R
		445516	B WING_		06/2	28/2019
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
CREEKS	IDE CENTER FOR RE	HABILITATION AND HEALING		306 W DUE WEST AVENUE MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETION DATE
{K 541}	Continued From patchutes 2012 EXISTING (1) Any existing line pneumatic rubbish a directly onto any corresistive constructions shall be provided with a fire protection rations shall comply with 9.4 (2) Any rubbish church pneumatic rubbish a provided with automin accordance with 9.4 (3) Any trash chute a collection room used protected in accordal aundry chutes permoom are protected accordance with 19. (4) Existing fuel-fed by fire resistive consuse. 19.5.4, 9.5, 8.4, NFF	n and trash chute, including and linen systems, that opens ridor shall be sealed by fire n to prevent further use or the a fire door assembly having ng of 1-hour. All new chutes 5. The or linen chute, including and linen systems, shall be atic extinguishing protection 0.7. Shall discharge into a trash of for no other purpose and ance with 8.4. (Existing litted to discharge into same by automatic sprinklers in 3.5.9 or 19.3.5.7.) incinerators shall be sealed truction to prevent further	{K 54	The single laundry chute has been plated Out of Service effective 7/2/19 and clearly marked. The laundry chute is additionally behind a locked door with an additional sign indicating Out of Service. The Director of Maintenance was in-serviced by the Administrator on 7/2/19 per the requirements listed on the 2567. The laundry chute door will be placed on a daily check to ensure it is not being used to ensure compliance with K 541 for two weeks then weekly thereafter until substantial compliance is achieved. The results of the audit will Be reported in the monthly QA		7/3/19
	by: Based on observation maintain the laundry	ons, the facility failed to chute.		Meeting for a period of (3) months June – August 2019. Or until substantial compliance is achieved.		
; ; ;	the holes in the laund covered with a piece nstalled on the laund the door to self-close NFPA 101, 19.5.4.1 (/2019 at 8:44 AM, revealed dry chute door had been of sheetmetal and the latch dry chute door did not allow and latch within the frame. 2012 Edition) NFPA 101, NFPA 82, 5.2.3.3.1.1 (2009		The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeepin & Laundry Director, and Maintenance Director.	g	
211 0110 050	Z(02 00) Provious Varsions O	hoolete Event ID: 308522	E	acility ID: TN1939 If continu	eation shee	t Page 3 of 5

OMB NO. 0938-0391

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 093					
STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING	COM	E SURVEY PLETED			
		445516	B. WING				R 28/2019			
NAME OF	PROVIDER OR SUPPLIER	443010		S	TREET ADDRESS, CITY, STATE, ZIP CODE	007	LUILUIJ			
CREEKS	SIDE CENTER FOR RE	EHABILITATION AND HEALING			06 W DUE WEST AVENUE IADISON, TN 37115					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE			
{K 761} SS=D	these deficiencies of Administrator acknown during the exit configuration of 28/2019. Maintenance, Inspector of CFR(s): NFPA 101 Maintenance, Inspective definition of the Doors assembly annually in accordation for Fire Doors and of Non-rated doors, in patient rooms and stroutinely inspected maintenance program in the strong possess known that demonstrates at Written records of immaintained and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NFI This REQUIREMENT by: Based on document ensure fire doors astested annually in act and ard for Fire Doors and the findings included the Document review or facility did not provide an annual inspection assemblies during 2	Director was present when were identified and the owledged these deficiencies erence (via phone call) on ection & Testing - Doors ection & Testing - Doors eies are inspected and tested ince with NFPA 80, Standard Other Opening Protectives. Cluding corridor doors to smoke barrier doors, are as part of the facility am. Ing the door inspections and owledge, training or experience ability. Inspection and testing are available for review. (2) PA 80) IT is not met as evidenced of treview, the facility failed to esemblies are inspected and ecordance with NFPA 80, nors and Other Opening	{K 5		The Maintenance Assistant completed the inspection and testing of the fire doors fro 7/1/19 - 7/3/19. All results were reviewed the Director of Maintenance on 7/3/19. The annual fire door inspection will be placed on the TELS automated system for tracking to ensure test are performed annually in the future. The Administrator in-serviced the Director of Maintenance on the door auditing requirements on 7/3/19 per the requirements of the 2567. The Director of Maintenance will complete a routine audit monthly of all fire doors for a period of (3) months to ensure compliant with K 761 June — August or until substantial compliance is achieved. The results of the monthly audits will be presented by the Director of Maintenance in the monthly Quality Assurance meeting to assure compliance with the requirements of K 761. June — August 2019 or until substantial compliance is maintained. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeepin & Laundry Director, and Maintenance Director.	m l by ced g	7/3/19			

OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING 01 - MAIN BUILDING		TE SURVEY MPLETED
		445516	B. WING		1	R /28/2019
NAME OF I	PROVIDER OR SUPPLIER		Ĭ	STREET ADDRESS, CITY, STATE, ZIP CODE		
				306 W DUE WEST AVENUE		
CREEKS	SIDE CENTER FOR RE	HABILITATION AND HEALING		MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
{K 761}	(2012 Edition) NFPA NFPA 80, 5.2.1 (201 (2010 Edition) The Maintenance Di these deficiencies w Administrator ackno	ge 4 Edition) NFPA 101, 8.3.3.1 A 80, 5.2.3 (2010 Edition) D Edition) NFPA 80, 5.2.4 irector was present when there identified and the wledged these deficiencies brence (via phone) on	{K 76			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING AND PLAN OF CORRECTION 05/01/2019 B. WING 445516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVENUE CREEKSIDE CENTER FOR REHABILITATION AND HEALING MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 INITIAL COMMENTS K 321 New doors ordered for the basement general Stories: 1 storage room and the basement accounting storage Construction Type: NFPA, II (000); IBC, II rooms on 5/14/19. unprotected Some plans available on site A 100% inspection of all other facility doors was Constructed: 1968 Conducted on 5/13/14 to ensure all Sprinklered: Yes Census: 130 Were in compliance with the requirements of A Life Safety Code Survey was conducted by the State of Tennessee Department of Health The Director of Maintenance was in-serviced Division of Health Licensure and Regulation on 5/8/19 as to the requirements listed on the Office of Health Care Facilities on 04/29/2019 2567 it relates to the condition of doors throughout and 04/30/2019. During this Life Safety Survey, the center. Creekside Center for Rehabilitation and Healing was found not in substantial compliance with the A 100% audit of all doors will be completed monthly requirements for participation in For the next (3) months to ensure continued Medicare/Medicaid at 42 CFR Subpart 483.70(a), Compliance with K 321 and the results will be Life Safety from Fire, and the related National Reported In the monthly QAPI meeting May -Fire Protection Association (NFPA) standard July 2019. 101-2012. The results of the monthly The requirement at 42 (CFR), Subpart 483.70(a) 6/15/19 is NOT MET as evidenced by:

Hazardous Areas - Enclosure K 321 SS=D

CFR(s): NFPA 101

Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied

K 321

audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K 321.

May - July 2019.

The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, **Business Office Manager, Social Services** Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

- 1. Observation on 04/30/2019 at 11.57 Aid, revealed the door to the basement general storage room did not self-close within the frame and the door was spliting at the sides. NFPA 101, 19.3.2.1.3 (2012 Edition)
- 2. Observation on 04/30/2019 at 12:11 AM, revealed the door to the basement accounting storage room did not self-close within the frame. NFPA 101, 19.3.2.1.3 (2012 Edition)

The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies

Facility ID: TN1939

If continuation sheet Page 2 of 8



Event ID: 3C8S21



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

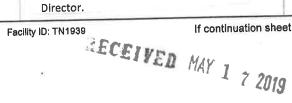
FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES					0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE	ECONSTRUCTION 01 - MAIN BUILDING	(X3) DATE COMP	PLETED
		445516	B. WING			05/0	1/2019
	PROVIDER OR SUPPLIER	EHABILITATION AND HEALING		30	REET ADDRESS, CITY, STATE, ZIP CODE 06 W DUE WEST AVENUE IADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D RF	(X5) COMPLETION DATE
K 324	Cooking Facilities CFR(s): NFPA 101	age 2 ference on 04/30/2019.		321 324	K 324 The Dietary Director in-serviced the ne Member #1 on 4/30/19 and again on 5 who was new and in orientation on to ensure compliance with K324.	w staff 5/9/19	6/15/19
	with NFPA 96, Star and Fire Protection Operations, unless * residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities compartments with with the conditions or * cooking facilities 30 or fewer patient 18.3.2.5.4, 19.3.2. Cooking facilities per 9.2.3 are not rehazardous areas, corridor. 18.3.2.5.1 through 19.3.2.5.5, 9.2.3, 7	ag equipment (i.e., small is microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke a 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, in smoke compartments with as comply with conditions under 5.4. Orotected according to NFPA 96 equired to be enclosed as but shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through TIA 12-2			The Dietary Director in-serviced 100% remaining dietary staff on 5/9/19 to additionally ensure all staff were aware of how to activate the hood suppression system and the use of a fi extinguisher as a secondary means. The Staff Development Director added Specific fire suppression information in the dietary new hire orientation page on 5/9/19. The Director of Dietary will audit all neemployees monthly for (3) months to ensure new staff are education prior to working in the dietary department. The results of the monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K 324. May — July 2019. The Quality Assurance Performance	re d cket ew o	
	by:	JIREMENT is not met as evidenced observations, the facility failed to cooking facilities.			Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers,		
	The findings include				Business Office Manager, Social Servi Director, Dietary Manager, Housekee & Laundry Director, and Maintenance	eping	1
	Interview on 04/30)/2019 at 11:40 PM, revealed			Director.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3C8S21

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(X3) DATE SURVEY

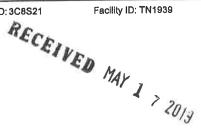
(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING IDENTIFICATION NUMBER: 05/01/2019 B. WING 445516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVENUE CREEKSIDE CENTER FOR REHABILITATION AND HEALING MADISON, TN 37115 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 353 K 324 K 324 | Continued From page 3 The wiring attached to the sprinkler pipe in the kitchen staff member #1 did not know the know the proper fire control procedures including; the front entrance will be within compliance on manual activation of the hood suppression or before 6/15/19. system, and the activation of the hood suppression system as the primary means of fire An inspection of all other sprinkler piping was suppression and the use of a fire extinguisher as completed on 5/12/19 to ensure no a secondary means. NFPA 101, 19.3.2.5.1 (2012 other wires were attached to sprinkler Edition) NFPA 96, 10.2.1 (2011 Edition) NFPA 96, piping. 10.5.7 (2011 Edition) The Director of Maintenance was Maintenance staff was present when these In-serviced by the Administrator on 5/8/19 deficiencies were identified and the administrator on the requirements listed on the 2567. acknowledged these deficiencies during the exit conference on 04/30/2019. The Director of Maintenance will audit the 6/15/19 K 353 K 353 Sprinkler System - Maintenance and Testing sprinkler pipes monthly for (3) months to SS=D | CFR(s): NFPA 101 additionally ensure compliance to K 353. Sprinkler System - Maintenance and Testing The results of the monthly Automatic sprinkler and standpipe systems are audits will be presented inspected, tested, and maintained in accordance in the monthly Quality Assurance with NFPA 25, Standard for the Inspection, meeting to assure compliance Testing, and Maintaining of Water-based Fire with the requirements of K 353. Protection Systems. Records of system design, May - July 2019. maintenance, inspection and testing are The Quality Assurance Performance maintained in a secure location and readily Improvement Committee will include available. but not be limited to the following: a) Date sprinkler system last checked Administrator, Medical Director, Director of Nursing, Unit Managers, b) Who provided system test Business Office Manager, Social Services c) Water system supply source Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Provide in REMARKS information on coverage for Director. any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3C8S21

Facility ID: TN1939

If continuation sheet Page 4 of 8



FINITLD, UJIVEIEU IO FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING AND PLAN OF CORRECTION B. WING 05/01/2019 445516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVENUE CREEKSIDE CENTER FOR REHABILITATION AND HEALING MADISON, TN 37115 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 353 K 353 | Continued From page 4 Based on observations, the facility failed to K 521 maintain the sprinkler system. A contracted vendor is scheduled to complete The findings included: The regulred fire damper Inspection on 5/22/19. Observation on 04/29/2019 at 10:13 PM, revealed a bundle of communication wires attached to and supported by a sprinkler pipe in the front entrance The fire damper inspection will cover 100% lobby. NFPA 101, 19.3.5.1 (2012 Edition) NFPA of all fire damper system requirements 101, 9.7.5 (2012 Edition) NFPA 25, 5.2.2.2 (2011 to ensure inspection compliance with Edition) K521 on 5/22/19. The Maintenance Director was present when The Director of Maintenance was these deficiencies were identified and the in-serviced by the Administrator Administrator acknowledged these deficiencies on 5/8/19 on the requirements during the exit conference on 04/30/2019. listed on the 2567. K 521 K 521 HVAC 5/22/19 SS=D CFR(s): NFPA 101 The Director of Maintenance will report the status of the **HVAC** inspection to the Administrator Heating, ventilation, and air conditioning shall upon completion. comply with 9.2 and shall be installed in accordance with the manufacturer's The results of the damper specifications. Inspection will be presented 18.5.2.1, 19.5.2.1, 9.2 In the monthly Quality Assurance meeting to assure compliance with the requirements of K 541. May and/or July. The Quality Assurance Performance This REQUIREMENT is not met as evidenced Improvement Committee will include by: but not be limited to the following: Based on document review, the facility failed to Administrator, Medical Director, maintain the HVAC systems. Director of Nursing, Unit Managers, **Business Office Manager, Social Services** The findings included: Director, Dietary Manager, Housekeeping Document review on 04/29/2019 at 10:45 AM, & Laundry Director, and Maintenance revealed the facility failed to conduct a 4 year fire Director.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

I INNTILD. UDIUZIZUTS **FORM APPROVED** OMB NO. 0938-0391

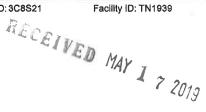
(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING B. WING 445516 05/01/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVENUE CREEKSIDE CENTER FOR REHABILITATION AND HEALING MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 521 Continued From page 5 K 521 damper inspection. NFPA 101, 19.5.2.1 (2012 Edition) NFPA 101, 9.2.1 (2012 Edition) NFPA K 541 90A, 5.4.7.1 (2012 Edition) NFPA 80, 19.4 (2010 Edition) The laundry chute door was removed and will be repaired to remove the holes, ensure latch The Maintenance Director was present when mechanism is installed, and hinges are these deficiencies were identified and the in proper working order on or before Administrator acknowledged these deficiencies 6/15/19. during the exit conference on 04/30/2019. K 541 Rubbish Chutes, Incinerators, and Laundry Chu K 541 6/15/19 The center layout was reviewed and no SS=D CFR(s): NFPA 101 additional laundry chutes are present in the center on 5/1/19. Rubbish Chutes, Incinerators, and Laundry Chutes The Director of Maintenance was 2012 EXISTING In-serviced by the Administrator on (1) Any existing linen and trash chute, including 5/8/19 per the requirements pneumatic rubbish and linen systems, that opens listed on the 2567. directly onto any corridor shall be sealed by fire resistive construction to prevent further use or The laundry chute door will be placed shall be provided with a fire door assembly having on the TELS system to check weekly a fire protection rating of 1-hour. All new chutes to ensure compliance with K 541. shall comply with 9.5. (2) Any rubbish chute or linen chute, including The results of the weekly audit will pneumatic rubbish and linen systems, shall be Be reported in the monthly QA provided with automatic extinguishing protection Meeting for a period of (3) months in accordance with 9.7. May - July 2019. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and The Quality Assurance Performance protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same Improvement Committee will include room are protected by automatic sprinklers in but not be limited to the following: accordance with 19.3.5.9 or 19.3.5.7.) Administrator, Medical Director, (4) Existing fuel-fed incinerators shall be sealed Director of Nursing, Unit Managers, by fire resistive construction to prevent further Business Office Manager, Social Services use. Director, Dietary Manager, Housekeeping 19.5.4, 9.5, 8.4, NFPA 82 & Laundry Director, and Maintenance This REQUIREMENT is not met as evidenced Director. by:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		445516	B. WING	-	05/01/2019	
	SUMMARY ST (EACH DEFICIENC	EHABILITATION AND HEALING ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVENUE MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	LD BE COMPLÉTIO	
K 761 SS=D	The findings included the door to the laund holes and did not I Edition) NFPA 101 101, 5.2.3.3.1.1 (2) The Maintenance I these deficiencies Administrator acknowledge during the exit community in the exit community in accordate for Fire Doors and Non-rated doors, in patient rooms and routinely inspected maintenance programment of the programment of the exit community in the exit community in accordate for Fire Doors and Non-rated doors, in patient rooms and routinely inspected maintenance programment of the exit of t	ations, the facility failed to ry chute. Jed: Jao/2019 at 11:16 AM, revealed andry chute was damaged with atch. NFPA 101, 19.5.4.1 (2012, 9.5.2 (2012 Edition) NFPA 2009 Edition) Director was present when were identified and the owledged these deficiencies ference on 04/30/2019. Tection & Testing - Doors Jection &	K 76	The Maintenance Director completed the inspection and testing of the fire doors on 5/13/19. The Maintenance Director completed a 10 inspection of all fire doors in the center or 5/13/19 to ensure compliance with K 761. The annual fire door inspection will be pla on the TELS automated system for tracking to ensure test are performed annually in the future. The Administrator in-serviced the Director of Maintenance on the door auditing regular ments on 5/8/10 per the	n DO% n ced g	5/13/19

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING B. WING 05/01/2019 445516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 306 W DUE WEST AVENUE CREEKSIDE CENTER FOR REHABILITATION AND HEALING MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 761 K 761 Continued From page 7 Standard for Fire Doors and Other Opening Protectives. The findings included: Document review on 04/29/2019 at 10:50 AM, the facility did not provide documentation of an annual inspection and testing of the fire door assemblies during 2018. NFPA 101, 19.7.6 (2012 Edition) NFPA 101, 4.6.12 (2012 Edition) NFPA 101, 4.6.12.4 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.3 (2010 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/29/2019.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	AIR MO	. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED R
		445516	B. WING			06	/28/2019
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION AND HEALING			6 W DUE WEST AVENUE ADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 000}	A Emergency Preparts conducted by the Department of Heal Licensure and Registration Facilities survey on Emergency Preparts Center for Rehabilities	paredness Follow up Survey he State of Tennessee Ith Division of Health ulation Office of Health Care 06/28/2019. During this edness Survey, Creekside ation and Healing was found	{E 0	00}	est ester		
	for participation in E Regulations for Lon Federal CFR §483. *All deficiencies pre	viously cited on 4/30/2019 are eficiencies were cited on					
	DURECTORIS OR PROVIDE	EDISTIDDI IED DEDDESENTATIVE'S SIGN	TATTIRE (AA	TITLE		(X6) DĄTE
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	AIGNE	//(TITLE	71	13/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		445516	B. WING _		05/01/2019
	F PROVIDER OR SUPPLIER	EHABILITATION AND HEALING		STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVENUE MADISON, TN 37115	03/01/2013
(X4) II PREFI TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	A Emergency Preconducted by the Sof Health Division of Regulation Office on 04/30/2019. Dureparedness Sun Rehabilitation and substantial complia participation in Emergency Precederal CFR §483. The requirement at MET as evidenced Plan Based on All FCFR(s): 483.73(a)(for Emergency Pland Maintain an emergency P	42 CFR, §483.73 are NOT by: lazards Risk Assessment	E 006	E 006 Elopement was added to the Vulnerability Assessment on 4/30/19. All other risk assessment Items were revie on 4/30/19 to ensure all risk factors were included on the Vulnerability Risk Assessment. The Vulnerability Risk Assessment will be updated on or before November 30, 2019 and will include any updates that are needed. The Vulnerability Risk Assessment will be reviewed by the interdisciplinary team at the next QA meeting in May 2019. The Quality Assurance Performance	
	on and include a do community-based ri all-hazards approact *[For ICF/IIDs at §4 and include a docur community-based ri all-hazards approact	cumented, facility-based and sk assessment, utilizing an h, including missing residents. 83.475(a)(1):] (1) Be based on nented, facility-based and sk assessment, utilizing an h, including missing clients.		Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	
BORATOR	Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SECULD MAY 7 7 2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

CLIVIL	TO TOT MEDIO/ ITE	G MEDIO/ND GETTTIGES					
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
		445516	B. WING			05/	01/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	UDE OFNITED FOR DE	THARM ITATION AND UEALING		30	06 W DUE WEST AVENUE		
CREEKS	SIDE CENTER FOR RE	EHABILITATION AND HEALING		M	IADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
E 006	Continued From pa	ge 1	Ε(006	E 015		
	(2) Include strategi	es for addressing emergency		. 1	The Emergency Disaster Manual		
	events identified by	the risk assessment.			total number was updated		
					to include staff, volunteers, and		
		§418.113(a)(2):] (2) Include			residents for food, water, medical		
		essing emergency events			and pharmaceutical supplies		
		tified by the risk assessment, including the agement of the consequences of power			on 4/30/19.		
	failures, natural disasters, and other emergencies				The Emergency Dispetor Manual		
		e hospice's ability to provide			The Emergency Disaster Manual Alternate sources of energy was		
	care.				updated to reflect the current		
		NT is not met as evidenced			emergency power source, lighting,		
	by:	s, the facility failed to		ĺ	fire detection, extinguishing, and		
	complete the risk a			alarm systems in place.			
	Federal CFR §483.	ch per the requirements of			The Quantity of Provisions and all		
	1 000101 01 11 3 100.				emergency support equipment will		
	The finding include	l:			be updated on or before November		
					30, 2019 and will include any updates		
	facility's facility base	2019 at 1:30 PM, revealed the ed/community based risk			that are needed.		
		emergency preparedness			The assessment of numbers, food, wat		
3		ize an all-hazards approach			supplies, and pharmaceuticals along w		
	including the asses	sment of missing residents.		i	the emergency support equipment will reviewed by the interdisciplinary team	be	
	This finding was ve	rified by the administrator			for the next three months at the		
		of the facility's emergency			Quality Assurance meeting May –		
	preparedness progr	ram.			July 2019.		4/30/19
E 015		for Staff and Patients	EC)15			
SS=E	CFR(s): 483.73(b)(1)			The Quality Assurance Performance		
	(h) Policies and are	poodures [Facilities] must			Improvement Committee will include		
		ocedures. [Facilities] must nent emergency preparedness			but not be limited to the following:		
		ures, based on the emergency			Administrator, Medical Director,		
		agraph (a) of this section, risk			Director of Nursing, Unit Managers,		
		graph (a)(1) of this section,			Business Office Manager, Social Service		
		ition plan at paragraph (c) of			Director, Dietary Manager, Housekeepi & Laundry Director, and Maintenance	ng	
	this section. The po	licies and procedures must be			Director.		

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FORM APPROVED
OMB NO. 0938-0391
(X3) DATE SURVEY

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	IG	COMPLE	
		445516	B. WING_		05/01/	/2019
	PROVIDER OR SUPPLIER	HABILITATION AND HEALING		STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVENUE MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) OMPLETION DATE
E 015	reviewed and update minimum, the policite address the following: (1) The provision of and patients whether place, include, but at (i) Food, water, medical supplies (ii) Alternate source following: (A) Temperatures safety and for the safety and provisions. (B) Emergency light (C) Fire detection systems. (D) Sewage and water (D) Sewage and proced (E) The following are hospice-operated in the policies and proced (E) The policies and proced (E) The following: (iii) The provision of hospice employees evacuate or shelter limited to the following: (A) Food, water, resupplies. (B) Alternate sour following: (1) Temperature and safety and for the following: (2) Emergency	ded at least annually.] At a les and procedures must ag: I subsistence needs for staff or they evacuate or shelter in are not limited to the following: dical and pharmaceutical as of energy to maintain the sto protect patient health and afe and sanitary storage of an aghting. In extinguishing, and alarm waste disposal. Indice at §418.113(b)(6)(iii):] ures. I additional requirements for patient care facilities only. In occurrence must address the subsistence needs for and patients, whether they in place, include, but are not and patients, and pharmaceutical arces of energy to maintain the les to protect patient health are safe and sanitary storage	E 01	5		

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY IPLETED
		445516	B. WING			05/	01/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CREEKS	SIDE CENTER FOR RE	HABILITATION AND HEALING			06 W DUE WEST AVENUE MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 015	systems. (C) Sewage and of This REQUIREMENT by: Based on document facility failed to include for the subsistence the emergency preparation of the findings included and the emergency preparation of the policies and quantity of provision staff and patients which shelter in place, included pharmaceutical supplication of the procedures for Altern Temperatures to propare extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and provisions, Emerger extinguishing, and a significant supplication of the safe and supplicatio	waste disposal. IT is not met as evidenced It review and interviews, the ide all policies and procedures needs of residents and staff in baredness program. It is not met as evidenced It review and interviews, the ide all policies and procedures needs of residents and staff in baredness program. It is not met as evidenced needs of residents and staff in paredness program. It is not met as evidenced needs of residents and staff in paredness program. It is not met as evidenced needs of residents and staff in paredness program. It is not met as evidenced needs of residents and staff in paredness program. It is not met as evidenced I	EO	15			
1	during the interview preparedness progra	Information	E 0:	30			4/30/19
 	emergency prepared	st develop and maintain an dness communication plan ederal, State and local laws					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445516	B. WING				05/01/2019	
NAME OF PROVIDER OR SUPPLIER CREEKSIDE CENTER FOR REHABILITATION AND HEALING			STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVENUE MADISON, TN 37115					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED DEFICIENCY)	BE	(X5) COMPLETION DATE	
	annually. The commall of the following: (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Other [facilities] (v) Volunteers. *[For RNHCIs at §4 communication plar following: (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Next of kin, gual (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416. plan must include a (1) Names and confollowing: (i) Staff. (ii) Entities providing: (ii) Patients' physici (iv) Volunteers. *[For Hospices at §4 communication plar following:	yed and updated at least munication plan must include tact information for the g services under arrangement. ians 03.748(c):] The must include all of the tact information for the g services under arrangement. In a communication are tact information for the following: tact information for the g services under arrangement. 45(c):] The communication are tact information for the g services under arrangement. 418.113(c):] The must include all of the tact information for the tact information f	E	030	The Emergency Disaster Manual was Updated on 4/30/19 to include The updated contact numbers for all staff, entities providing services Under arrangement, physician Contact, other facilities, and Volunteers. The Emergency Disaster Manual will contact information will be updated as needed bases and at least annually based on terminations, hiring, and/or contracting of new services. The Director of Human Resources will review the contact list and report findit to the interdisciplinary team for the next three months at the Quality Assurance meeting May — July 2019. The Quality Assurance Performance Improvement Committee will include, but not be Ilmited to, the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Service Director, Dietary Manager, Housekeep & Laundry Director, and Maintenance Director.	ings		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	. 03/02/2019 I APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY MPLETED
		445516	B. WING			05/	/01/2019
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CREEKS	IDE CENTER FOR RE	HABILITATION AND HEALING			ADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 030	(iii) Patients' physici (iv) Other hospices. *[For HHAs at §484 plan must include a (1) Names and confollowing: (i) Staff.	g services under arrangement. ians. .102(c):] The communication Il of the following: ntact information for the	E 0	30			
	plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service Ar This REQUIREMEN by: Based on document	tact information for the g services under arrangement. donor hospitals in the OPO's rea (DSA). IT is not met as evidenced at review, the facility failed to cation plan that includes					
	revealed the facility information for all fa This finding was ver	n 04/30/2019 at 1:45 PM, did not have contact cility staff. rified by the administrator of the facility's emergency					

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FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CREEKSIDE CENTER FOR REHABILITATION AND HEALING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) INCLINE LE CONTINUENT (X2) INDENTIFY INCLINE (X2) INDENTIFY INCLINE (X4) IN PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X6) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X7) INDENTIFY INCLINE (X2) INDENTIFY INCLINE (X3) INDENTIFY INCLINE (X4) IN INCLINE IN	CLIVILI	NO I OIL WILDIOMILE	C WILDION OF CELLING			WAL DATE	
NAME OF PROVIDER OR SUPPLIER CREEKSIDE CENTER FOR REHABILITATION AND HEALING (XA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) E 031 Continued From page 6 E 031 Emergency Officials Contact Information SS=D CFR(s): 483.73(c)(2) (E) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (E) Contact information for the following: (E) Cracinities at §483.73(c): [2) Contact information for the following: (Feor LTC Facilities at §483.73(c): [2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Contact information for the following: (Feor ICF/IIDs at §483.475(c):] (2) Conta	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CREEKSIDE CENTER FOR REHABILITATION AND HEALING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) E 031 Continued From page 6 E 031 Emergency Officials Contact Information CFR(s): 483.73(c)(2) (C) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (I) Federal, State, tribal, regional, and local emergency preparedness staff. (Ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (I) Federal, State, tribal, regional, and local emergency preparedness staff. (Ii) The State Licensing and Certification Agency. (Iii) The State Licensing and Certification Agency. (Iv) The State Licensing and Certification Agency. (Iv) The State Licensing and Certification Agency. (Ivi) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced			445516			05/0	01/2019
PREFIX TAG Continued From page 6 E 031				30	6 W DUE WEST AVENUE		
E 031 Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iii) The State Licensing and Certification Agency. (iv) The State Licensing and Certification Agency. This REQUIREMENT Is not met as evidenced E 031 The contact information for FEMA and TEMA were added to the Emergency Disaster Manual on 4/30/19. The contact information for FEMA and TEMA were added to the Emergency Disaster Manual on 4/30/19. The contact information for FEMA and TEMA were added to the Emergency Disaster Manual on 4/30/19. A review of the Emergency Disaster plan was reviewed by the Administrator on 4/30/19 to ensure no additional contact number was missing. A full review of the contact information will be performed by the Administrator And findings presented to the interdisciplinary team for the next three months at the Quality Assurance meeting May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Midical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services D	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
Based on interview, the facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies in the	E 031	Emergency Official CFR(s): 483.73(c)([(c) The [facility] memergency prepare that complies with and must be review annually.] The comall of the following: (2) Contact informa (i) Federal, State emergency prepare (ii) Other source *[For LTC Facilities information for the (i) Federal, State, the emergency prepare (ii) The State Licent (iii) The Office of the Ombudsman. (iv) Other sources of information for the (i) Federal, State, the emergency prepare (ii) Other sources of information for the (ii) Federal, State, the emergency prepare (iii) Other sources of iii) The State Licent (iv) The State Prote This REQUIREME (iv) The State Prote This REQUIREME (iv) The State, tributed and procedure and p	ust develop and maintain an edness communication plan Federal, State and local laws wed and updated at least munication plan must include ation for the following: a, tribal, regional, and local edness staff. s of assistance. at §483.73(c):] (2) Contact following: ribal, regional, or local edness staff. sing and Certification Agency. The State Long-Term Care of assistance. 483.475(c):] (2) Contact following: ribal, regional, and local edness staff. following: ribal, regional, and local edness staff. In assistance. In a sistance and Advocacy Agency. The state is not met as evidenced we, the facility failed to include dures for primary and alternate nicating with facility staff, al, regional, and local		The contact information for FEMA and TEMA were added to the Emergency Disaster Manual on 4/30/19. A review of the Emergency Disaster plan was reviewed by the Administrator on 4/30/19 to ensure no additional contact number was missing. A full review of the contact information Will be performed by the Administrator And findings presented to the interdisciplinary team for the next three months at the Quality Assurance meeting May — July 2019. The Quality Assurance Performance improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeepin & Laundry Director, and Maintenance	s	4/30/19

		AND HUMAN SERVICES			FORM APPROVED MB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		445516	B. WING_		05/01/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CREEKS	SIDE CENTER FOR RE	EHABILITATION AND HEALING		306 W DUE WEST AVENUE MADISON, TN 37115	ū
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
E 031	requirements of Fed The finding included Interview on 04/30/2 facility had no reconfor primary and alter communicating with emergency manage emergency. This finding was ver	deral CFR §483.73. d: 2019 at 1:50 PM, revealed the rd of polices and procedures rnate means for a facility staff, Federal, State rement agencies during an rified by the administrator of the facility's emergency	E 03	31	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3C8S21

Facility ID: TN1939

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